REPORT TO: - System Resilience Group
NSCHT Commissioning Board

Date of Meeting:	System Resilience Group – 26th May 2016 NSCHT Commissioning Board – 25th May 2016
Title of Report:	QIA – Shared Care Ward (Ward 4)
Presented by:	Jane Munton-Davies
Author of Report:	Jane Munton-Davies
Purpose / Intent of Report:	A decision is required as to future commissioning of the Dual Care Ward situated on Ward 4.
Executive Summary:	This paper presents a QIA for the Dual Care service hosted within Harplands Hospital Ward 4, at the request of System Resilience Group. Ward 4 was opened in January 2015 in response to significant system pressures and a major capacity incident. Since that point due to the work of clinical staff across organisational boundaries the ward has developed and provides high quality care to patients with a combination of physical health needs and Dementia that were previously un-catered for. The service has been robustly evaluated with overwhelmingly positive results. There is national evidence to support dual care facilities. Dementia is a significant and growing area of need and it is vital that services are developed to appropriately support patients with Dementia, such as ward 4. This paper outlines the impact and achievements of ward 4. It also outlines risks and mitigations if it were to be decommissioned. It concludes that Ward 4 is a model that should be supported and askes for SRG support for substantive commissioning so that dialogue between CCGs and NSCHT can take place to facilitate this.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: 17th May Date: Document Version number:

Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research at all levels. ☐ 4. Maximise and use our resources intelligently and efficiently.☒ 5. Attract and inspire the best people to work here.☒ 6. Continually improve our partnership working. ☒ 7. To enhance service user and carer involvement.☒ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	Risks and mitigations of withdrawal identified in paper
Resource Implications: Funding source:	The paper is to request funding for ward 4 in line with previously produced financial modelling and business case.
Equality & Diversity Implications:	The service is specifically for patients with Dementia, which is a growing area of need. Withdrawal would leave this group less well served by local health services.
Recommendations:	1. SRG and CCG Commissioners are asked to note the positive impact of ward 4 and associated evidence based on evaluation and data. 2. SRG and CCG Commissioners are asked to note the risks and potential mitigations if the service were ceased. 3. SRG and CCG Commissioners are asked to support the conclusion that Ward 4 should be substantively commissioned. 4. Subject to recommendation 3 being accepted, CCG Commissioners are asked to work with NSCHT to achieve recommendation 3.

QUALITY IMPACT ASSESSMENT
Ward 4 – Shared Care Service

This QIA record is intended to be used to assess the impact of quality on issues that relate to service users and carers such as performance issues, emerging circumstances, business cases and change activities

1.0 Introduction

The Shared Care Service on Ward 4, Harplands Hospital is a unique facility that delivers improved patient outcomes and critically supports flow across the local health economy. The service has a proven track record in enabling increasing numbers of patients to return home and reducing the number of patients being admitted to nursing homes. At times of system pressure the service offers additional capacity that is able to minimise the risk of extended length of stay in the Acute Trust.

The prevalence of older people with dementia is set to double over the next 30 years in the UK as the ageing population rises and recognition improves. According to the Department of Health (DoH) costs will have risen from £17 billion in 2008 to £50 billion in 2039.

An Alzheimer's Society report, (Counting the Cost – Caring for people with dementia on hospital wards 2009) indicated:-

- 42% of individuals aged over 70 years with unplanned admission to an acute hospital have dementia; rising to 48% in those aged over 80 years.
- 47% of carers said that being in hospital had a significant negative effect on the physical health of the person with dementia, which wasn't a direct result of a medical condition.
- 54% of carer respondents said that being in hospital had a significant negative effect on symptoms of dementia, such as becoming more confused and less independent.
- Over a third of people with dementia who go into hospital from living in their own homes are discharged to a care home setting.

The same Alzheimer's Society also identified key areas of dissatisfaction for patients and carers in their experience of general hospital wards as below:

- Staff not understanding/ recognising dementia
- Patients are not helped adequately to eat and drink
- Lack of dignity and respect
- Limited opportunity for social interaction
- Not enough collaboration with carers in decision making

Patients with dementia are particularly vulnerable in acute hospitals as they are highly susceptible to environmental changes and find it difficult to communicate their needs. "Hospital services are intrinsically geared towards fast and effective responses, assessment, diagnosis, intervention, cure [if possible] and discharge. Services run on the assumption that patients will be able to express their wishes, acknowledge the needs of other patients and move through the system as required"

In Commitment to the Care of People with Dementia in Hospital Settings, RCN 2013
Shared Care Ward models have demonstrated;

- Improved assessment and management for older people with the most complex needs
- Reduced length of stay
- Improved outcomes for rehabilitation
- Increased frequency of discharge to lower levels of care

This seemed to be a sound test of the benefit of ward 4 added to cost benefits and this has been used as an assessment template and includes as appendix 1 of this document.

Spencer et al (2013) conducted a qualitative study of specialist Medical and Mental Health Units and Standard Acute Wards. They found that specialist Medical and Mental Health Units offered a higher level of expertise around dementia and reduced incidents of Behavioural and psycho-social disorder (BPSD). There was found to be increased communication and involvement of family and carers and "relationship-centred" care through a named nurse approach.

2.0 Background

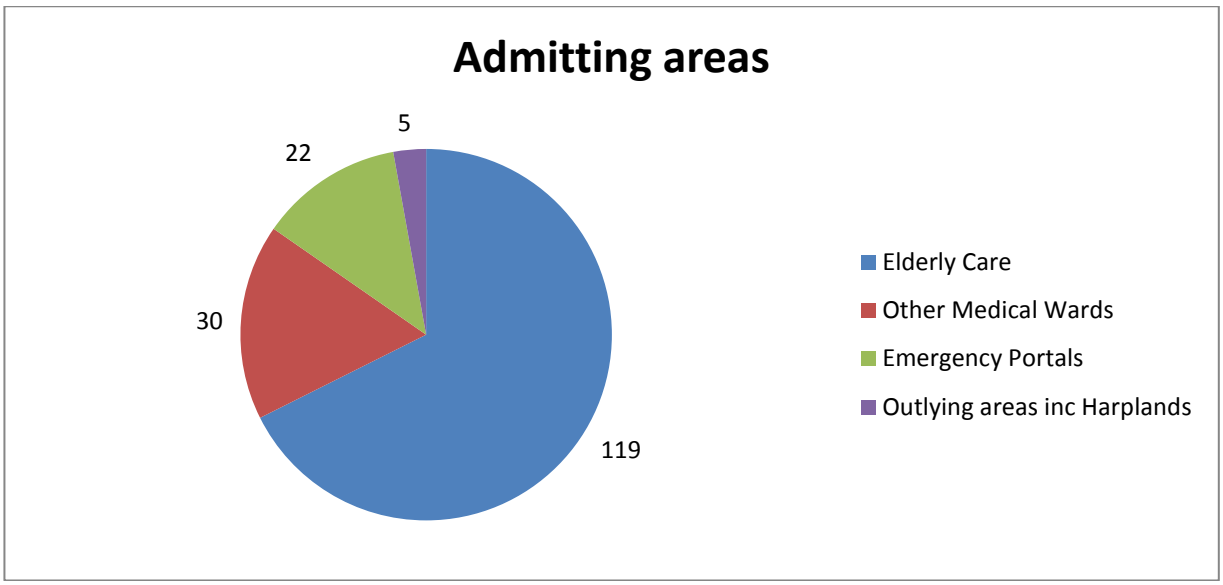
Ward 4 developed in January 2015 in response to Winter Pressures and the declaration of a major system capacity incident that particularly impacted on the Royal Stoke Hospital site and across UHNM. The ward has adopted a "Shared Care" philosophy drawing on mental health expertise from Registered Psychiatric Nurses (RMN's) and Registered General Nurses (RGN's) provided by UHNM.

The Team is medically led by a Geriatrician and a Consultant Psychiatrist who have joint responsibility for the patients. All RMNs on the ward have been given additional training in physical health skills and are confident in administering IV therapy. An operational policy has been developed to support this.

The service has unique co-dependencies with other health and social care services such as RAID, Outreach, CMHT's and EMI stay at home schemes. This enables efficient patient identification at UHNM through RAID practitioners and where possible patients are transferred directly from emergency portals and the Frail Elderly Assessment unit to Ward 4. Primary sources for admission are elderly care wards, CDU and Frail Elderly Assessment Unit (see chart overleaf).

George et al (2011) reviewed a number of shared care models and concluded that "The ideal service model is a psychiatric liaison service linked to a joint shared care ward."

The strong relationships with allied mental health teams such as Outreach make it possible to support patients discharge early and safely through providing support and expertise at home whilst minimising risks as far as practicable.



3.0 Current Position

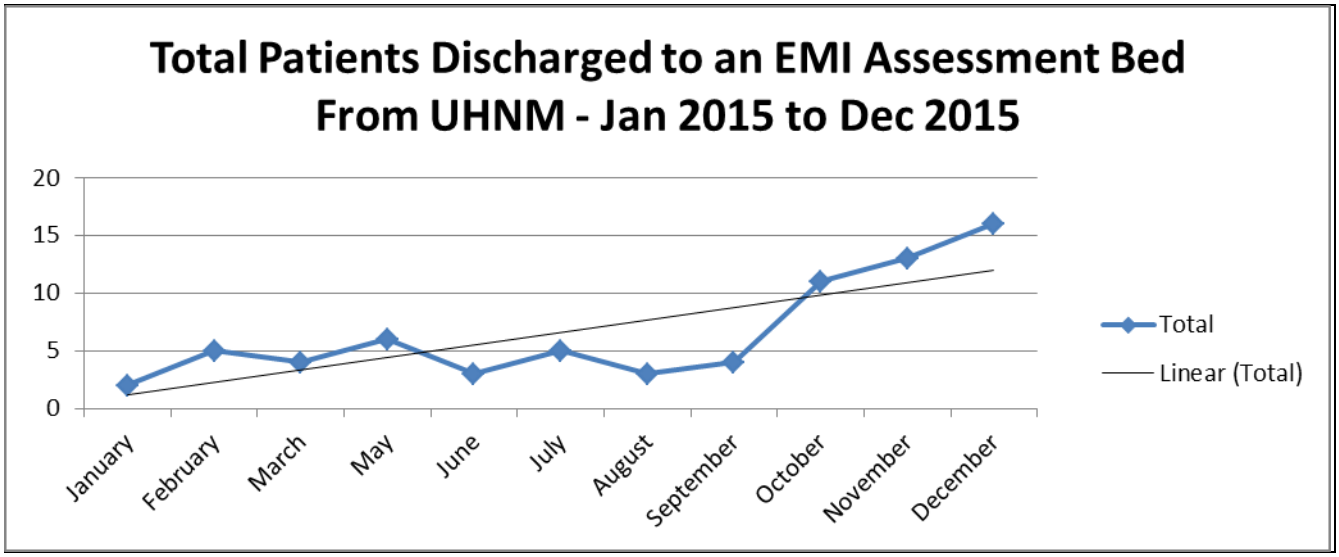
There are currently 17 beds as part of the shared care service on Ward 4 (the ward has been operating substantively as a 15 bed ward for most of the year and increased to 17 in Jan 16). These are accessed through the onsite RAID team and proactive in-reach from the ward staff.

As part of the economy wide plan to support the reduction in delayed transfers of care and improve flow across the system, there is a particular focus on patients who are deemed medically fit for discharge (MFFD). Combined Healthcare has adopted a proactive approach to managing the flow and egress of these patients through early identification and expectation management. The discharge flow process is detailed in the attached operational policy and essentially seeks to embed the SAFER patient flow bundle in a shared care setting.

Strong relationships with partner agencies and the SPEED team at The Royal Stoke have enabled the proactive pull function of the RAID team to support transfers directly from emergency portals and FEAU to prevent unnecessary moves through the elderly care wards, thereby improving the patient experience.

Between January 2015 and January 2016 it can be seen from the chart below that there has been a steady but significant increase in demand for EMI assessment beds by patients at Royal Stoke University Hospital. From October through to December there was a 340% increase in demand for EMI assessment provision (see chart below). Where these patients cannot be stepped down to alternative provision they remain on the Acute ward whilst a comprehensive assessment of needs takes place. At the present the only alternative Dementia assessment and rehabilitation beds are at Marrow House in Stoke-on-Trent.

The most significant cohort of EMI delays within the Acute Trust were waiting for an EMI Assessment bed (52.5%) followed by Care Package /EMI Stay at Home (20%).



3.1 Admission and Transfer

Ward 4 accepts patients who meet the following criteria:

- Usually over the age of 65. There are occasions when it may be deemed appropriate and in a patient's best interest that they come to ward 4 before this age.
- Diagnosis of dementia (Patients with a strong suspicion of dementia will be considered).
- Be medically stable for discharge from UHNM.
- Have a provisional discharge plan identified.
- Have Continuing Healthcare checklist completed if appropriate
- It is expected that where a patient has been on an acute ward for some time that the assessment process including completion of saps should commence without unnecessary delay. Completed SAPs should come to Ward 4 with the patient.

Patients admitted from emergency portals will be accepted without discharge route or associated paperwork.

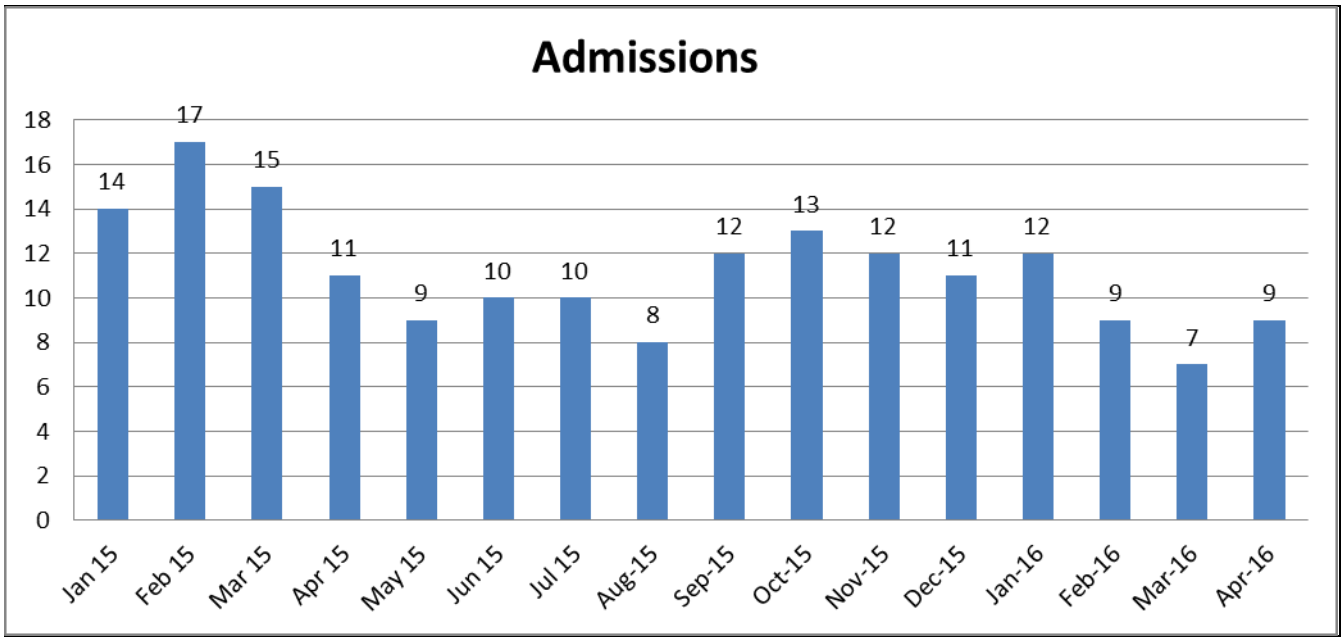
3.2 Exclusion criteria

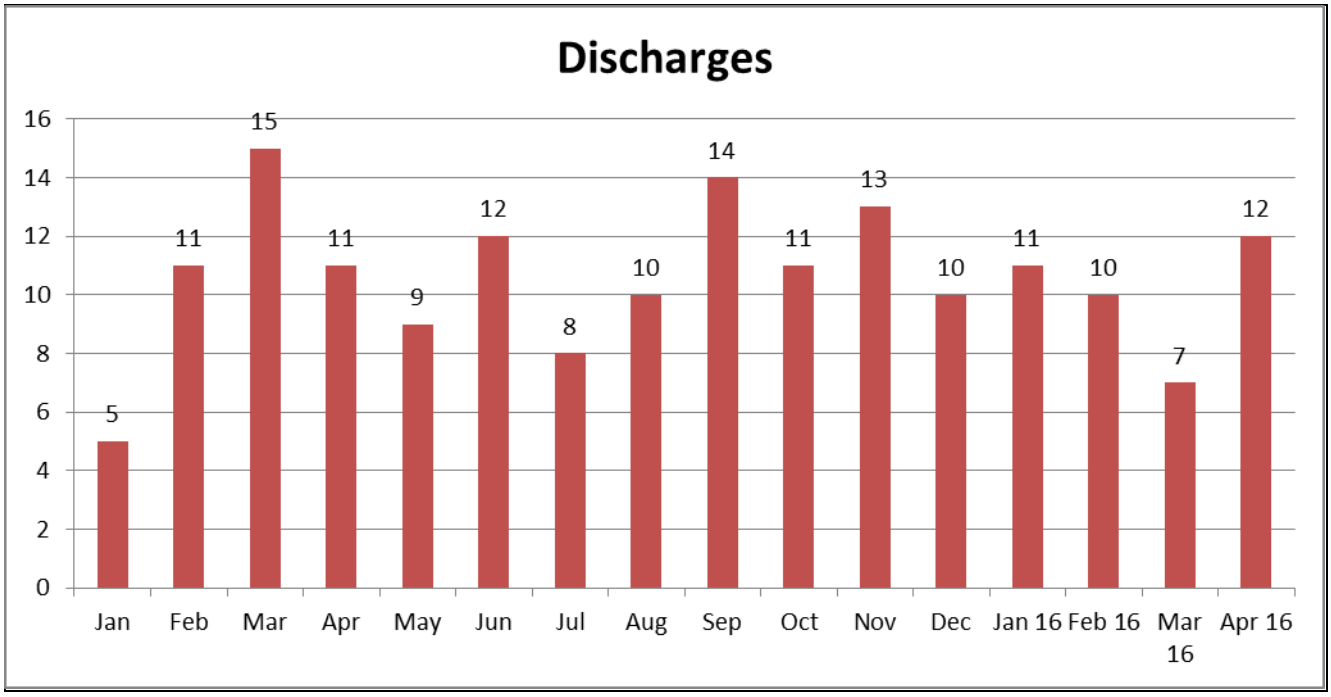
- The ward does not accept patients from out of area.
- The ward does not accept patients who remain medically unstable.
- Patients who experience **high** levels of Behavioural and Psycho Social Disorder (BPSD). These patients may be more appropriate for RAID referral and consideration for Ward 6

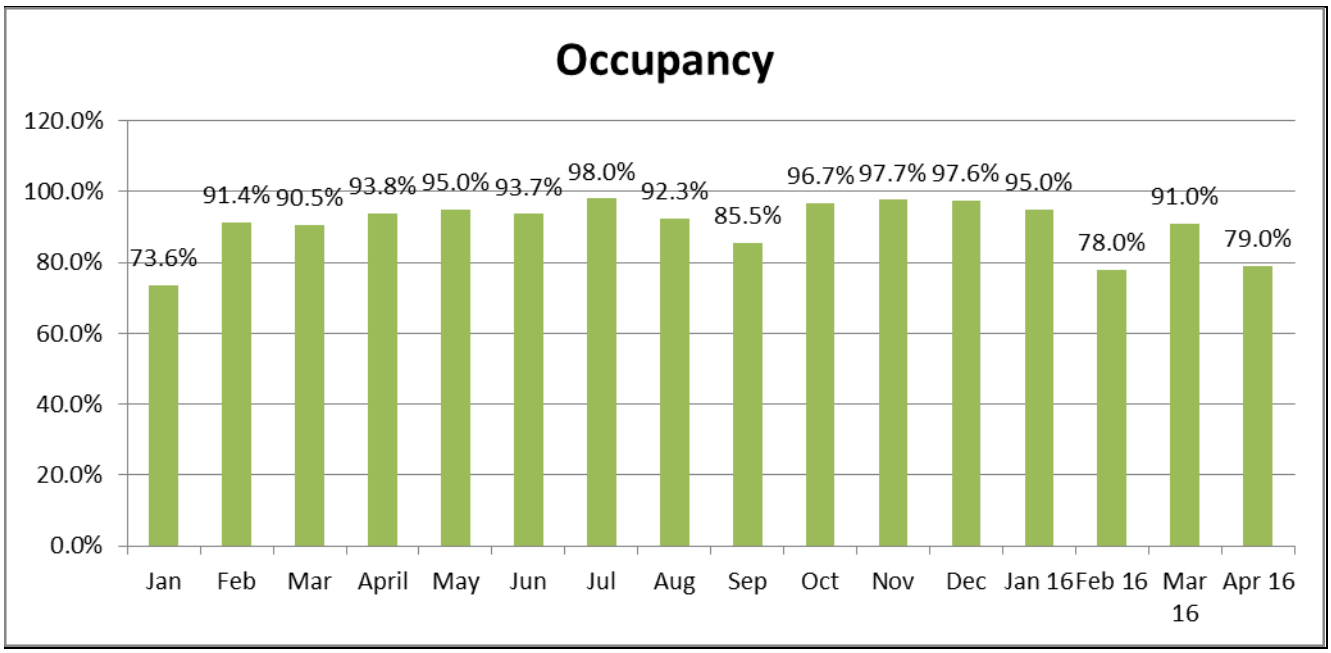
3.3 Activity

Activity on the ward is reflected in the charts below with admissions peaking in line the ward starting to take the first cohort of patients at the beginning of the year. Both admissions and discharges slowed down over the summer as the complex assessments began to be worked

through and multi-disciplinary teams were established. Length of stay also peaked over this timeframe.
Over the last few months the level of activity for both admissions and discharges has increased. Bed occupancy had steadied at 98% with a dip in February and April 2016 due to temporary infection control restrictions. Length of stay has been variable due to the increasing complexity of patients being accepted and managed on the ward. Delayed transfers of care have also shown a variable picture with particular difficulties being experienced around Patient Choice, Funding and Provider assessment.






Occupancy
120.0%
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91.4%
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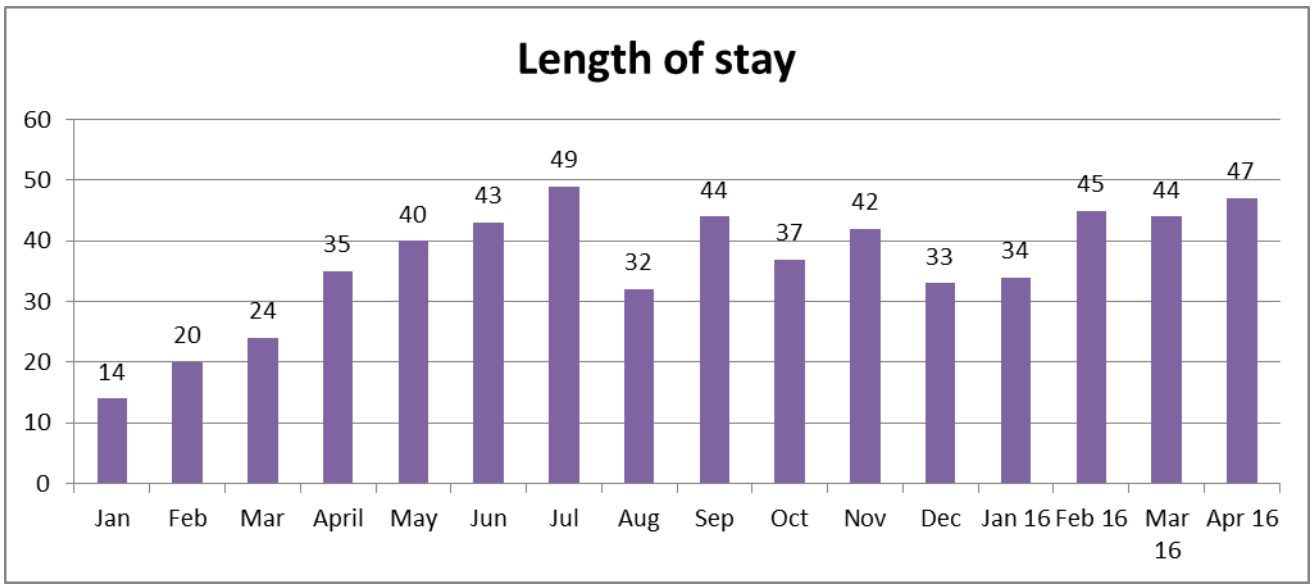
Length of stay
60
50
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10
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14
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24
35
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49
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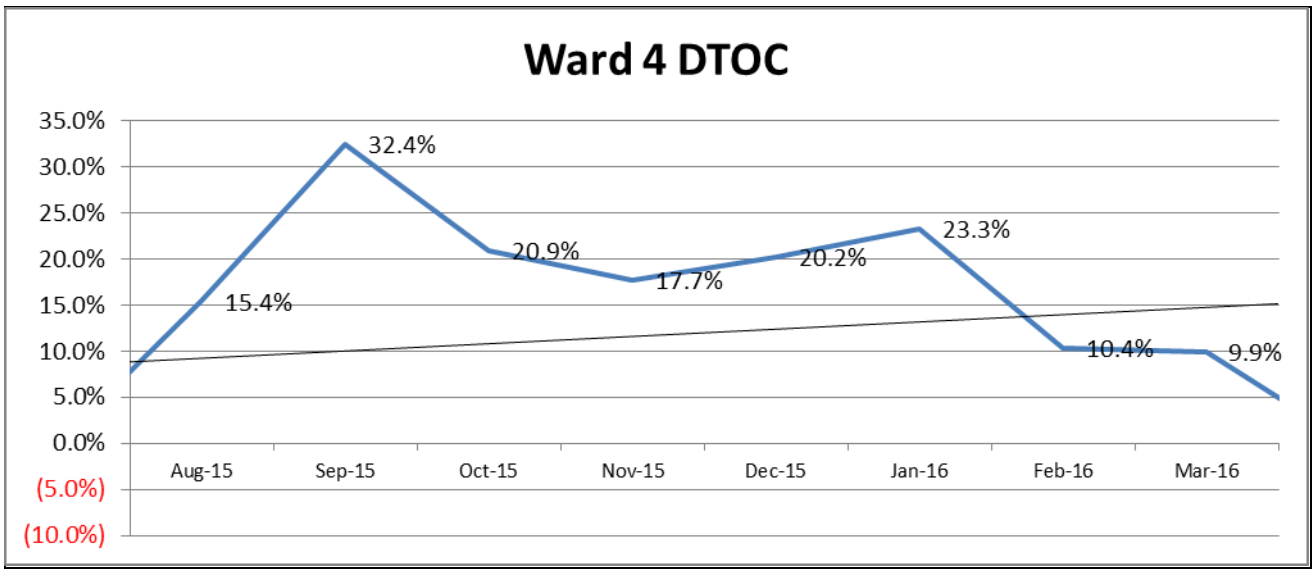
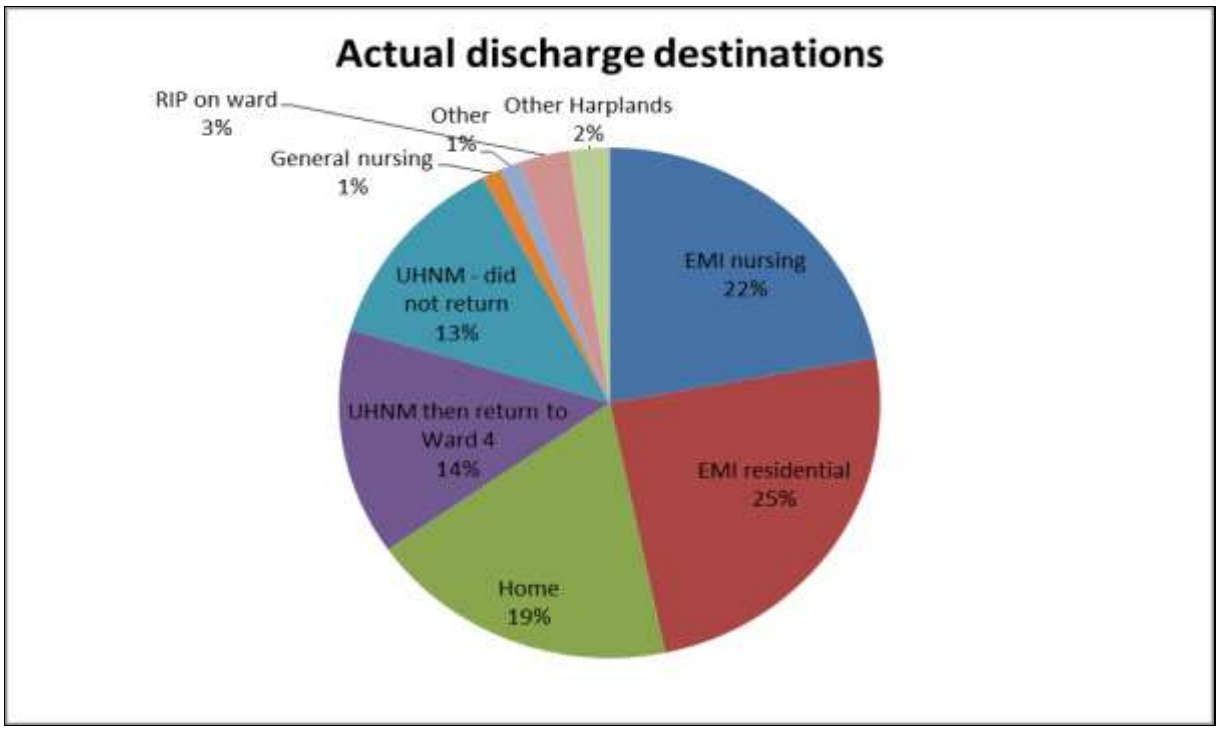


4.0 Outcomes and Evidence

Patients who move to Ward 4 from UHNM benefit from an enablement philosophy which focusses on each individual maximising their potential. There is significant input on the ward from therapy staff and activity workers, which reflects in patients being out of bed, dressed and engaging in meaningful activities.

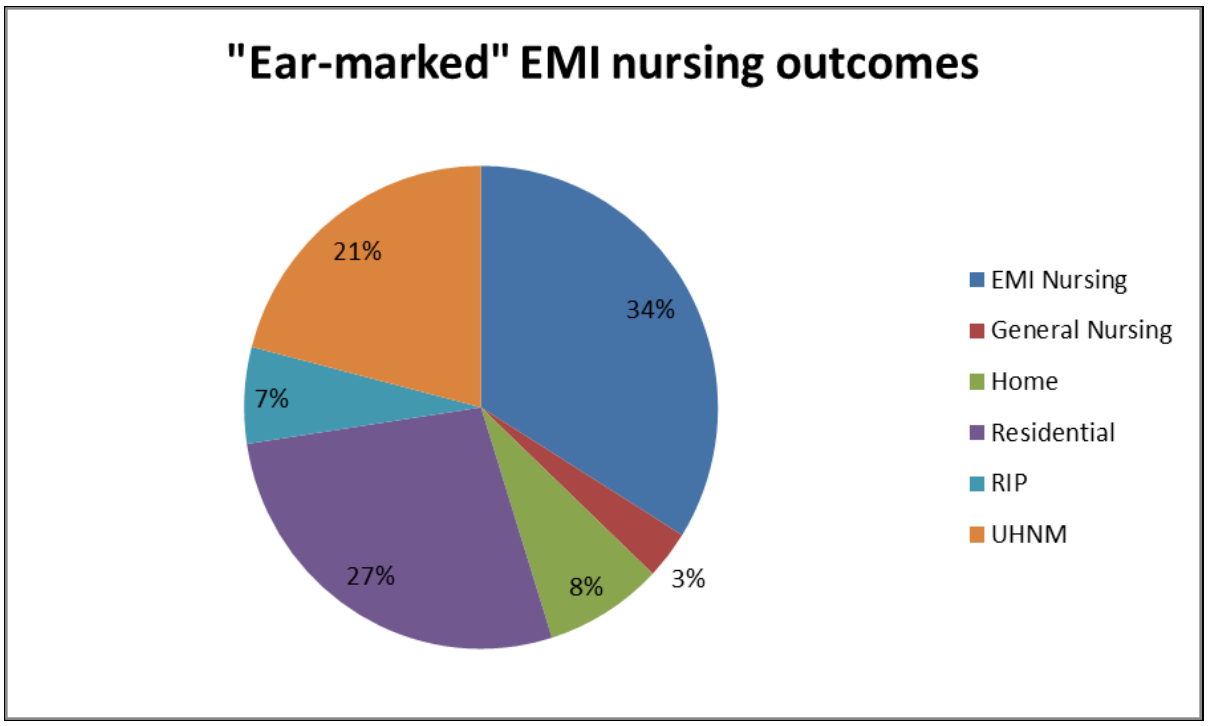
Whereas in the initial phase of the ward opening patients were to arrive with their discharge destination set and agreed, the increasing levels of independence observed during their stay has led to many patients undergoing full reassessments of their needs. Overall the outcome destinations for patients have demonstrated a reduction in levels of dependency. This is supported by the data below, showing that 19% of this complex patient cohort have been supported to return home.



Most notably, as indicated by the graph overleaf, where patients admitted to ward 4 had an identified discharge destination to a nursing home the ward has been successful in reducing the level of placement required. This supports both the operating model deployed in ward 4 and the benefit of assessment in an appropriate environment.

Which magazine estimated that for 2015 the average cost of a Nursing Home bed was £790 per week and a nursing home £587. Partnership estimate these figures to be £731 and £529 respectively, thus both broadly there is an estimated saving of £200 per week for placement in a care home versus a nursing home, equating to a saving of £10,400 per patient per year in care costs.

Partnership estimate the cost of Domiciliary Care as £15 per hour, thus someone receiving 3 x 1 hour calls per day 7 days a week would incur a cost of £315 per week, a minimum saving of £416 per week (£21,632 per year). Based on this cohort alone it is likely that there is an ongoing cost saving of approximately £284k per annum.



4.1 External Evaluation

Since its inception, Ward 4 has been the subject of extensive external review and evaluation including by commissioners, the NHS Trust Development Authority (now NHS Improvement), Healthwatch Stoke on Trent, the Trust Comprehensive CQC inspection in September 2015 and by Fusion 48, which was the commissioned review of System Resilience schemes. All reviews undertaken have been positive and full copies are available on request. Of note the following observations were made:-

Healthwatch Stoke on Trent – who visited the ward on 18th March 2015 concluded that:-

- Ward 4 provides a quiet, calm, caring environment for patients; a 'step down' for patients who no longer need an acute setting but may need some further help, towards physical and mental improvement including any medication reviews.
- It provides 'shared care' which works well with the appropriate skill mix to help patients with both physical and mental health needs.
- The time spent here also supplies the opportunity to ensure that an accurate, suitable care package is provided so that instead of moving directly to a Care Home patients may be given the opportunity to live more independently and happily at home.
- It was interesting to note that all staff, patients, and relatives spoken to were all very enthusiastic about the Ward, the only difficulty being that some patients wanted to remain there.

The **Fusion 48** report, which was the evaluation of 15/16 system resilience funded schemes concluded that ward 4 was of significant benefit and made the following observations:-

- 'The shared care beds on ward 4 provided a unique opportunity for partnership and cooperation between UHNM and NSCHT. The shared focus of improving care led to a dynamic approach to the delivery of this innovative new service and was generally

perceived to have had wider impact in promoting joint working across both organisations'

- 'Although the shared care beds on ward 4 was implemented on an extremely short timescale, exceptional clinical leadership had supported a rapid cycle of learning and development. The service demonstrated a positive multi-disciplinary team approach and strong cross-organisational working, as well as flexibility and 'clinical common sense'. The Cross Economy Transformation Team have completed a detailed and comprehensive review of this service as part of their review of older people's mental health services, we strongly endorse their positive conclusions.
- '…ward 4 in conjunction with some of the cross organisational development work already carried out by the 'Star Chamber' to establish and agree a cross economy governance framework which will be able to overcome challenges long associated with transitions of care and will be fit for purpose to support the 'new models of care' described in the NHS Five Year Forward View.

Care Quality Commission

The Trust's comprehensive CQC visit took place in September 2015. During this Older People's Mental Health Services were rated 'Good'. Ward 4 was specifically identified under the area of good practice, with the following commentary:-

- 'Ward 4 had been re-opened as a shared care ward and demonstrated how good joint working between acute and mental health services could bring great benefits and improve outcomes for patients'

Elsewhere in the report the following observations were made

- Patients' physical health, as well as their mental health, was monitored and treated effectively with a clear focus on recovery and discharge in a timely manner. Joint working between the mental health & acute trusts on ward 4 was working particularly well in speeding and enhancing patients' recovery.
- 'One relative visiting ward 4 told us, "It's beautiful here. This is the cleanest hospital we've been in". Domestic staff we spoke with were highly motivated, proud of their work and felt an integral part of the teams.
- Ward 4 had both general and mental health nurses working together, sharing knowledge and skills to achieve optimum outcomes for patients' physical and mental wellbeing.
- Joint working between the mental health & acute trusts on ward 4 was working particularly well in speeding and enhancing patients' recovery.

The only issues raised relate to the volume of bank and agency staff in place on the ward. Although the Trust has recruited a number of posts we would be able to resolve this if the ward is substantively commissioned. Additionally a comment was made about the amount of social space, which has been resolved.

4.2 Patient Exemplars

A number of case studies have been collected showing the impact of ward 4 on the patient cohort and are enclosed below:-

A. Initially on admission it was agreed that A would need 24 hour EMI nursing care. However there was a significant change in A's presentation within the new ward environment. He was more interactive with his family and staff, his hostility reduced significantly and for the first time in months he began to mobilise with a frame. Due to the improvement it was agreed for A to return home. The Outreach Team facilitated as a ward leave arrangement.

   This went very well and A was discharge home with a support package of 3 care calls per day. The Outreach Team reported that A continued to improve at home.
   A's wife was delighted this outcome and stated to staff, "I am very pleased with my husband's care; he's speaking more now than in the last 6 weeks. He's like a different person."

B. Patient B was transferred from the Royal Stoke to Ward 4 unable to walk and with an identified discharge destination as residential care. He engaged well with the nursing and therapy staff on the ward and his mobility and living skills improved vastly. B progressed to mobilising well with a rollator frame and the discharge plan was revised to return home.

   B had successful periods of leave with the Outreach Team before being discharged with a care package and is managing well at home.

C. Patient C was initially unhappy about being transferred to ward 4 as she didn't see the point. This was reflected in her interactions for the first few days as she was disengaged with staff.

   Over the next week she developed a rapport with care staff and began to socialise and interact with others on the ward. She enjoyed participating in activities, particularly the pamper sessions. It became apparent that the stay at home scheme had actually declined to support C in returning home. Residential care was considered as the most appropriate outcome, however with support from the Outreach Team she went home with a care package.

D. Patient D was admitted to UHNM and treated for Pneumonia. She had several grade 3 / 4 pressure ulcers and had been bed bound since December 2014. Staff on Ward 4 sought a pressure relieving cushion for D and she was supported to sit out in communal areas for 3 hours per day. This had a significant impact on her mood. D's independent living skills did not improve due to the advanced nature of her frailty, however the change in her mood and her interactions were significant. He diet & fluid intake also increased. On admission D was identified as needing 24 hour EMI nursing care however following an overall improvement in her mental health was able to be discharged to a residential care setting.

4.3 Benchmarking Data

There is still little compactor data available for Ward 4 as there is little published quantitive data on shared care wards. It has been possible to obtain some data for Willow House in Birmingham. This is an 18 bedded unit opened in 2014 based in a Dementia friendly environment. The unit has already won awards for design and delivery. Willow House. Over the time that Ward 4 has been opened this has had an average LOS of 34 days as opposed to 36 days for Ward 4.

4.4 Cost Comparison

Although based on agency costs the amount has previously been higher, the OBD identified for Ward 4 as per the business case is £298. This compares to £355, which we believe to be the case at Willow House. Although it has not been possible to obtain validated data locally it is understood that the relevant Community Hospital bed day cost is approximately £355. This would mean that ward 4 is at least competitive with comparable specialist facilities and levels of care.

5.0 What do we need to do now?

There is a need for a decision to be made around the intention to commission the shared care service on a recurrent basis in order to support stable staffing establishments and enhance the patient outcomes. There is a risk that if the Service is not commissioned that there will be an increase in stranded patients at UHNM and patients will be discharged to settings of higher dependence.

The outcomes of the Shared Care Service have been well documented and shared across the local health economy. In an economy where we are over –burdened with bed stock it is essential that we support the "correct" type of beds that deliver patient and system wide benefits. Commissioners are urged to consider the proven benefits of the service and the potential risks should this not be continued. The plan would be for the service to be continued.

6.0 Risks Associated with Ceasing the shared Care Service

It should be noted that the SRG QIA process has predominantly been focussed on capacity that the system has agreed is of limited value and will be closed.

As the numerous evaluations and evidence outlined in this report, it is proposed that Ward 4 should be substantively commissioned. It is further suggested that in a LHE which is struggling for capacity that it would be difficult to mitigate the withdrawal of the service. It is certainly outside of the capacity of NSCHT to give assurance that this could be achieved with no system impact, as in many cases the mental health needs of patients would not need to be catered for by a ward stay and/or the physical health needs are greater than those which would be accommodated on a traditional mental health ward.

It is further suggested that the clinically lead dual care approach developed in ward 4 should be a model on which services are developed in future.

Risks of doing so and potential mitigations are identified below.

Risks Identified	Mitigating Actions	Risk Rating
Patients with dementia and physical health needs will not benefit from holistic reablement focussed support that enable discharge to the setting of lowest dependency.	• RAID team to support and provide advice around management of complex patients on the wards at UHNM.	
There is a risk that patients will have a longer length of stay within UHNM due to current system delays within community services.		
There is a risk that utilising alternative spot purchase provision in nursing homes does not lead to patients maximising their potential and reduces the likelihood of them returning home.		
Increase in admissions to 24 hour care placements.		
Risk that the loss of capacity would have an adverse impact on patient flow across the health economy.	• Outreach team to support discharges.	

7.0 Quality Impact

7.1 What Impact on Safety does this have? *(Does this represent an improvement or increased risk of harm? Does this have the potential to impact on the safety of patients, carers, staff or any other people?*

Patients will not benefit from 24 specialist support in managing complex behaviours and psychiatric interventions. Carers will not have access to the same level of specialist knowledge to support in the discharge planning process. This will create both a capacity and flow issue to colleagues in UHNM but also the issue of supporting people with Dementia in busy Acute wards.

7.2 How does this impact on patient experience? *(Consider healthcare environment, social cost for patients/families, dignity and respect of patients their families and carers, impact on our reputation with patients (local or national media attention)*

Patients are supported to maximise their potential and where possible are supported to return home. There will be an impact in terms of potential reduction in people being supported home and increased admissions to 24 hour care.

Families and partner agencies such as Healthwatch Stoke on Trent have been conclusive on the value of the service and how this supports a positive patient experience. Cost comparison is also positive.

7.3 Is this likely to result in worse or improved clinical outcomes for patients? *(Have clinicians been involved in developing this? Evidence to support implementation (e.g. published case studies, best practice bundles, evidence based guidelines, NICE guideline). How do the clinical team monitor the outcome? What is happening to check and review progress?*

As per the evidence of Spencer et al and the Alzheimer's society research detailed in the introduction Shared Care Ward models have demonstrated;

- Improved assessment and management for older people with the most complex needs
- Reduced length of stay
- Improved outcomes for rehabilitation
- Increased frequency of discharge to lower levels of care

If the service were to be withdrawn there would be a negative impact upon the quality of assessment and care management, length of stay and patient outcomes.

7.4 What is the impact on access or waiting times? *(Consider impact on waiting times for diagnostics, clinical review or treatment and access to services)*

It is anticipated that there will be an increase in length of stay and "stranded patients" at UHNM. The Shared Care Service are able to uniquely support early discharge of patients where appropriate through the use of the Outreach team. This enables timely discharge home and reduces the demand upon the domiciliary market.

7.5 Impact across the Trust and wider health economy *(Consider any impact/consequences in other areas of the Trust/LHE (e.g. does this deliver improvement or savings in one area but with negative consequences in another). Does this initiative impact on service delivery and your ability to support other clinical teams and service users?*

There would be an anticipated impact upon levels of dependency should patients be discharged directly from UHNM. For some this would be in terms of requiring a more substantial care package and for others who may not have the opportunity to rehabilitate this would mean a direct admission to 24 hour care.

The "Home First" approach of the shared care service supports the ambitions of the local authorities in reducing admissions to 24 hour care.

There would be an impact on flow and length of stay in both the Acute Trust and Community Hospitals. Traditionally the patient cohort accepted onto Ward 4 would have protracted lengths of stay in inappropriate settings. This has the potential to exacerbate any behavioural issues without robust and skilled interventions.

7.6 Equality and Diversity *(Will this result in unfavourable treatment or disadvantage to staff, patients, families, carers in relation to Age, Disability, Gender re-assignment, Marriage and civil partnership, Pregnancy and maternity, race, Religion or belief, Gender, Sexual Orientation*

The will be a potential impact on older people with a mental health need as they will not benefit from a holistic assessment of their needs in an appropriate environment.

8.0 Directorate Sign Off

Clinical Lead: (if applicable) Dr. Darren Carr	Project Lead:(if applicable) Jane Munton-Davies
Contributors of this QIA:	QIA process Used:
Date of Initial QIA:	Date for post Implementation Review:

	Clinical / Professional Lead	Operational Lead
Name:	_____	_____
Signature:	_____	_____
Date:	_____	_____

9.0 QIA Recommendation

Based on all of the available evidence, significant evaluation, patient and partner feedback, patient response, patient experience and outcomes along with the potential impact of withdrawal of the service on the local health economy, there is an overwhelming case to substantively fund the service. Commissioners are therefore urged to commit to recurrently fund the Shared Care Service.

Appendix 1 – Evaluation of Ward 4 against RCN identified benefits and financial cost/benefit

As identified in the body of this document 'Commitment to the Care of People with Dementia in Hospital Settings' ; RCN 2013] identified that qualitatively that Shared Care Ward models have demonstrated;

- Improved assessment and management for older people with the most complex needs
- Reduced length of stay
- Improved outcomes for rehabilitation
- Increased frequency of discharge to lower levels of care.

We have added to this a cost/benefit section to create a summarised evaluation framework which is enclosed below.

Area of Benefit	Has this been demonstrated conclusively	How has it been evidenced
Improved assessment and management for older people with the most complex needs	✓	• Extensive evaluation identified within the QIA • Case studies included within QIA • Feedback from patients, carers and staff • Specialist expertise deployed • Improved pathway now in existence
Reduced length of stay	Requires further work to assess	There is no base model to assess against. It has been possible to get data from a Dementia friendly Community Hospital Ward in Birmingham and ward 4 is broadly comparable. There is little else directly comparable for the patient cohort. There is also work to do in respect of delayed transfers of care. It is accepted that social work teams prioritise Acute response given wider system issues. This makes direct comparison difficult.
Improved outcomes for rehabilitation	✓	• Extensive evaluation identified within the QIA • Case studies included within QIA • Discharge to lower levels of dependency

Area of Benefit	Has this been demonstrated conclusively	How has it been evidenced
Increased frequency of discharge to lower levels of care	✓	• 38% of patients earmarked for EMI nursing care were discharged to a setting of lower dependency than had been indicated on admission. • 25% of patients returned to place of ordinary residence. • 19% of patients went home with support.
Cost Benefit	✓	• Ward 4 is understood to be cost effective with an OBD cost of £298. This compares to £355 against a similar unit and what is understood to be a local community hospital bed day cost of around £350 per OBD. • Approximate saving in ongoing care costs of £284k in first 14 months of operation based on patients being transferred to lower levels of care thus reducing future costs.